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Title

Reproductive Health Care Priorities and Barriers to Effective Care for LGBTQ People Assigned Female at Birth: A Qualitative Study

Permalink
https://escholarship.org/uc/item/3xf7w77x

Journal
Women's Health Issues, 28(4)

ISSN
1049-3867

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Publication Date
2018-07-01

DOI
10.1016/j.whi.2018.03.002

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ABSTRACT

Background: Little research documents the self-identified reproductive health priorities and healthcare experiences of LGBTQ-identified individuals who may be in need of services.

Methods: We conducted in-depth interviews with a diverse sample of 39 female-assigned-at-birth individuals (ages 18-44), who also identified as lesbian, bisexual, queer and/or genderqueer, or transmasculine. Interviews were primarily conducted in-person in the Bay Area, CA and Baltimore, MD, with 11 conducted remotely with participants in other U.S. locations. We asked participants about their current reproductive healthcare needs, topics they felt researchers should pursue, and past reproductive healthcare experiences. Data were analyzed using a framework method, incorporating deductive and inductive thematic analysis techniques.

Results: Reproductive healthcare needs among participants varied widely and included: treatment of polycystic ovary syndrome and irregular menses, gender-affirming hysterectomies, and fertility assistance. Many faced challenges getting their needs met. Themes related to these challenges cross-cutting across identity groups included: primary focus on fertility, provider lack of LGBTQ health competency relevant to reproductive health priorities and treatment, and discriminatory comments and treatment. Across themes and identity groups, participants highlighted that sexual activity and reproduction were central topics in reproductive healthcare settings. These topics facilitated identity disclosures to providers, but also enhanced vulnerability to discrimination.

Conclusion: Reproductive health priorities of LGBTQ individuals include needs similar to cisgender and heterosexual groups (e.g. abortion, contraception, PCOS) as well as unique needs (e.g. gender affirming hysterectomies, inclusive safer sex guidance) and challenges in pursuing

23care. Future reproductive health research should pursue healthcare concerns prioritized by
24LGBTQ populations.

25

26BACKGROUND

27 Reproductive health researchers have begun to explore inclusion of LGBTQ female-
28assigned-at-birth (FAAB) individuals, including lesbian and bisexual women and transgender
29men (female assigned at birth, identify as male), in studies on contraception, abortion, and other
30acute health topics (Cipres et al., 2017; SFP, 2017), due in part to increased funding opportunities
31for researchers pursuing questions of LGBTQ health (Pérez-Stable, 2016).

32 Current research on lesbian and bisexual women and transgender men suggests that each
33of these groups face pregnancy-related challenges. For cisgender, female, same-sex couples, who
34typically lack a sperm-carrying partner, family formation and child-bearing can involve complex
35decision-making, burdensome legal and insurance navigation, and additional fertility support
36(Schwartz & Baral, 2015; Somers et al., 2017; Tornello & Bos, 2017). Transgender men often
37fight stigma and isolation associated with being male-presenting and pregnant, while also
38managing gender dysphoria during pregnancy and early child care (Ellis, Wojnar, & Pettinato,
392015; Light, Obedin-Maliver, Sevelius, & Kerns, 2014; MacDonald et al., 2016, 2016).
40Testosterone hormone replacement therapy (HRT) may also impact fertility of transgender men
41(IOM, 2011).

42 Preventive sexual and reproductive healthcare is also pertinent. Lesbian and bisexual
43women and transgender men are less likely to receive pap tests than their heterosexual and
44cisgender counterparts (Agénor, Krieger, Austin, Haneuse, & Gottlieb, 2014; Agénor, Muzny,

45Schick, Austin, & Potter, 2017; Peitzmeier, Khullar, Reisner, & Potter, 2014). Lesbian women 46may also have an increased risk of polycystic ovary syndrome (PCOS), though results are 47uncertain (Agrawal et al., 2004; De Sutter et al., 2008; Smith et al., 2011). Cisgender women 48who have sex with women, particularly young women with both male and female partners, may 49be at increased risk of HIV and sexually transmitted infections based on reported risk behaviors, 50including multiple sexual partners, substance use during sexual activity, and experiences with 51sexual coercion (Knight & Jarrett, 2017; Marrazzo & Gorgos, 2012). Transgender men who have 52sex with men may also be at increased HIV risk (Reisner & Murchison, 2016).

53 Despite burgeoning interest and documented concerns, reproductive health research on 54LGBTQ populations often lacks input from LGBTQ individuals in priority setting. We conducted 55in-depth interviews with 39 LGBTQ FAAB individuals to explore their priorities and 56experiences with reproductive healthcare.

57

58MATERIALS AND METHODS

59Sampling & Recruitment

60 We conducted in-depth interviews with 39 LGBTQ FAAB individuals between December 612016 and March 2017 after receiving human subjects approval by University of California, San 62Francisco. Interviews were conducted as part of a project to explore LGBTQ FAAB individuals' 63attitudes toward standard reproductive health survey items and to develop new, inclusive survey 64items and overall best practices for LGBTQ inclusion in reproductive health research (Ingraham, 65Wingo, Foster, & Roberts, 2017). We recruited participants through community-based social 66networks, including LGBTQ listservs, professional networks, postings at local LGBTQ

67organizations and Craigslist (Robinson, 2014). The researchers also asked participants to refer
68other LGBTQ-identified people they knew. Individuals were eligible if they were LGBTQ-
69identified, FAAB, and between the ages of 15 and 45. Anyone who expressed interest (n=97)
70filled out a questionnaire that included age, race/ethnicity, sex assigned at birth, current gender
71identity, and sexual orientation.

72 After evaluating feasibility based on initial participation interest, we undertook a
73maximum variation sampling strategy, a type of purposeful sampling (Patton, 2002), to ensure
74diversity in age, race/ethnicity, sexual orientation, and gender identity. We conducted a second
75wave of targeted recruitment using social media and Craigslist to recruit people of color and
76younger people, broadly speaking, with no quotas for individual age, race/ethnicity categories, to
77balance our early interviews that were largely with White, older participants. The researchers
78who conducted interviews are both cisgender, White, queer women who are personally and
79professionally active in LGBTQ communities. These factors likely influenced social networks
80available for convenience and snowball sampling, level of comfort between participants and
81researchers, and framing of interview questions.

82 Questions used to elicit reproductive healthcare priorities and experiences of participants
83were: "What is the most important reproductive health care issue for you personally and why?";
84"What has been your experience with reproductive health care?"; and "What should be done
85differently in reproductive health care?" We also asked participants about what topics they think
86reproductive health researchers should pursue. In discussing these topics, we did not define
87"reproductive health" for participants, instead letting them interpret the term for themselves. This
88allowed us to see what individuals considered reproductive health concerns and for what reasons
89individuals were seeking out reproductive healthcare providers. The interview guide was

reviewed within our reproductive healthcare research organization by two other researchers for clarity before data collection.

We conducted interviews in person in the Bay Area, California (N.I.) and Baltimore, Maryland (E.W.) in private locations agreed upon with participants. Eleven interviews were conducted over the phone or by video with participants located in other parts of the U.S. Prior to each interview, oral consent was obtained. Participants received a $40 gift card for their time.

After completion of 39 interviews, we concluded that saturation had been reached, as new interviews did not generate any new codes and confirmed existing codebook themes (Fusch & Ness, 2015).

Data analysis

Interviews were audio recorded, transcribed verbatim, and reviewed for accuracy of transcription. We conducted textual analysis via Dedoose (version 7.6.6). The two researchers who conducted data collection also completed data analysis; one is a sociologist with public health training and the other is a master’s level public health researcher, both familiar with the literature on LGBTQ health and trained in qualitative methods. We developed deductive codes based on research questions and previous literature. An additional set of emergent, inductive codes were created, agreed upon, and assigned during the review of the first five transcripts. To ensure inter-coder reliability, we developed a codebook and compared code usage between the first five coded transcripts and resolved any discrepancies by consensus. Analysis was conducted through a framework method (Pope, 2000; Ritchie & Lewis, 2014), placing coded transcripts into a series of coding matrices through which constant comparisons were made to establish themes. After identification of major themes, we reviewed transcripts stratified by sexual

orientation and gender identity to understand both the breadth of applicability and variation between different groups.

RESULTS

Analysis of data generated two domains presented here: reproductive health priorities and future research topics and barriers to effective reproductive healthcare. The latter is further divided into four thematic areas: fertility and women's care focus, LGBTQ erasure and health competency, discriminatory comments and care, and impact on future healthcare seeking behavior.

Participant Characteristics

A total of 39 participants, between the ages of 18 and 44, were interviewed with a mean age of 29.9. [insert Table 1 here] The majority of our sample (n=25) identified as queer, and a third identified as gay or lesbian (n=5) or bisexual (n=7). Just over half of the sample identified as female (n=21)[1]. An additional third (n=13) identified as genderqueer or gender non-conforming (identifying with neither, both, or a combination of male and female genders), and a sixth (n=5) identified as transgender men/transgender male. Over half of participants (n=22) identified as White, 15% as Black or African American (n=6), 15% as Hispanic (n=6); the remainder identified as Asian (n=2) or biracial (n=3). Overall, the sample was highly educated, with over three-quarters reporting at least a college degree (n=33). Slightly more than half reported full time employment (n=21).

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1 Participants were asked about gender identity using the Williams Institute measure (Gender Identity in U.S. Surveillance (GenIUSS), 2014). This instrument uses the terms "female" and "male", generally associated with sex, instead of the equivalent gender terms "women" and "man." Based on interviews with participants, all who indicated "female" identified as a cisgender woman.

23

132

133 **Reproductive health needs and future research topics**

134 Self-identified reproductive healthcare needs, listed in Table 2 [insert table 2 here],
135 varied. Acute and preventive concerns were reported by cisgender, genderqueer, and transgender
136 male participants. Younger participants identified routine preventive care, such as pap tests,
137 sexually-transmitted infection (STI) prevention, and birth control as priorities, while older
138 participants were generally concerned with childbearing or menopause. Participants across all
139 ages reported acute reproductive health concerns, such as pain management for PCOS or menses.
140 Two cisgender, queer participants were pregnant at the time of their interview and reported
141 LGBTQ-inclusive prenatal care as their most immediate need. Other cisgender, transgender, and
142 genderqueer participants interested in future pregnancy also cited fertility assistance and support
143 as a reproductive planning concern. Transgender participants with future desire to become
144 pregnant wanted to learn about the impact of testosterone hormone treatment (HRT) on fertility.
145 Transgender participants also cited gender-affirming care as a primary need, including some
146 combination of HRT, top surgery and hysterectomies. Two genderqueer participants had received
147 hysterectomies prior to interview. One reported concerns with HRT post-hysterectomy, while the
148 other sought further surgeries, such as oophorectomy (ovary removal). Lastly, one bisexual,
149 genderqueer participant and one queer, cisgender female participant mentioned abortion access
150 as an important service to have available.

151 We also asked participants about what reproductive health topics they thought researchers
152 should pursue. Many participants cited the experiences of LGBTQ FAAB individuals broadly, or
153 transgender people specifically, in reproductive-health settings as a priority, including
154 discrimination in reproductive health settings and cost of reproductive healthcare for LGBTQ

155FAAB individuals. Many also wanted to understand aspects of LGBTQ pregnancy, including: the
156experience of pregnancy for genderqueer people; how same-sex couples handle grief for
157pregnancy loss; and how HRT among transgender men impacts pregnancy-related outcomes. A
158few expressed interest in how LGBTQ individuals conceptualize family formation. Lastly, some
159participants listed sexual health research questions, including how LGBTQ individuals engage in
160sex (particularly transgender men) and what LGBTQ individuals use sex for (pleasure,
161reproduction, income, etc.), how to measure cisgender female same-sex safer sex practices, risk
162of STIs for women who have sex with women, and the reasons LGBTQ FAAB individuals use
163contraception—i.e. pregnancy prevention versus other reasons.

164**Reproductive healthcare barriers to effective care**

165 We identified a number of barriers encountered within reproductive healthcare settings,
166including: provider fertility focus, LGBTQ erasure and health competency, discrimination by
167providers, and impact of previous experiences on reproductive healthcare-seeking behavior.
168Participants defined "reproductive healthcare settings" as a broad range of settings, including:
169hospitals, private obstetrics and gynecology practices, and family planning clinics.

170*Fertility and women's care focus*

171 The association of reproductive care with fertility and womanhood pervaded stories in
172our sample. Many participants sought reproductive healthcare for acute health concerns.
173However, providers often steered them toward conversations about fertility, which "kind of sends
174the message that a woman's only purpose is to shoot children out of her uterus." (30-year-old,
175Black, queer woman). This made participants feel like their own health concerns were not as
176important to providers as filling child-bearing expectations externally ascribed to them. Several

177participants noted that this can be alienating to some LGBTQ FAAB individuals, including
178lesbian and bisexual women and transgender men, many of whom are not at risk of pregnancy
179and do not plan on having children.

180 This redirection was especially frustrating for participants seeking care for disruptive
181reproductive health issues. One queer woman described her experience being told that she had
182PCOS-associated infertility:

183Two different doctors told me this very, very gently, this was going to be terrible news to me. Yeah, not terrible
184news, really not. Just a lot of making assumptions about me wanting to protect or get involved in fertility ...and now
185I feel like I'm not getting good enough attention around the pain I'm having with my menstrual cycle. I call off work
186at least one day a month. This is not acceptable. -43-year-old, White, queer woman

187The participant had pronounced symptoms that she felt the provider was unprepared to handle,
188with the provider described as focusing on the aspect of PCOS least relevant to her life. This
189both obstructed quality healthcare and made her feel insignificant. For others, this framing by
190providers was dehumanizing. One 35-year-old, Black, queer, genderqueer person reflected:
191"They're just looking at me as a source of breeding."

192 Transgender men experienced the added level of complexity of reproductive care not
193only being associated with fertility, but with womanhood. One 29-year-old, White, queer,
194transgender man described how reproductive health centers are often labeled "women's health
195care" and as a result he feels uncomfortable and anxious as "the only guy in the waiting room
196that [isn't] with a woman." This created an additional obstacle to obtaining care for masculine-
197presenting individuals in our sample.

198

LGBTQ Erasure & Health Competency

Descriptions of erasure and inadequate provider competency were pervasive across both cisgender and gender variant participants. Many participants cited non-inclusive and outdated protocols as barriers to care. One pregnant cisgender participant, who used a known sperm donor for insemination, described how intake forms were confusing for her when receiving prenatal care:

> In both my obstetricians' offices, all the paperwork was very hetero-normative. It was very father of the baby, male partner. I did a lot of scratching out and writing over things. We have a known donor, so I'm lucky to know his medical history and all of that. And I recognize that that's important on the documentation, but it's unclear. Are you looking for this information for medical reasons or what? Because if it's for family reasons, my partner's information is more valid. -34-year-old, White, queer, cis woman

Lack of specificity and flexibility within intake forms made it difficult to properly communicate relationship and medical history information relevant to prenatal care. Similar observations were made by genderqueer and cisgender participants seeking preventive reproductive care, such as pap tests and STI screenings, who were unable to accurately report sexual behavior and gender or sexual identity on intake forms. The inexact language, based on embedded cis- and heteronormative assumptions, impacted their ability to communicate about risks.

Some providers also made behavioral assumptions when discussing sexual activity:

> Whenever health professionals throughout most of my life have asked me if I'm sexually active, they mean are you currently having a penis in your vagina, because in the end, they don't actually care about my sexual health. They care about … am I at risk for becoming pregnant, do I want to become pregnant, or do I have a risk of getting an STI from a penis? -26-year-old, White, queer, transgender man

Both cisgender and transgender participants described how providers inquired imprecisely about sexual activity while taking sexual histories and assessing risk. This left many participants feeling confused and invisible and lacking practical information. One cisgender participant summarized this feeling in relation to her gynecologist’s lack of engagement about same-sex sexual activity: "I don't know what the heck I'm supposed to do. And no one is talking about this [safe same-sex sexual activity]. Is it just not a thing? Does this not exist?" (22-year-old, biracial, queer, cis woman).

When cisgender participants proactively asked about same-sex sexual activity, providers were often described as unprepared. One 30-year-old, Black, queer, cisgender woman asked her provider during her postpartum visit when and how she could safely reinitiate sexual practices with her cisgender female partner. The participant described the provider as surprised and unprepared. Another participant was given expired dental dams without explanation of proper usage. One provider even inverted the provider-patient dynamic by asking their lesbian patients where the clinic could purchase dental dams. For individuals with acute sexual health concerns, the lack of guidance was especially frustrating. A cisgender woman with vaginismus was unable to obtain provider guidance on how to manage sexual activity with other cisgender women: “There was zero direction or image of what it meant to be a queer woman with vaginismus getting treatment. There was no end game. That basically didn’t exist, not really” (26-year-old, White, bisexual woman). For many participants, lack of both data and provider guidance made them feel invisible and anomalous, hindering their ability to receive relevant healthcare.

Discriminatory comments and care

Participants also encountered homophobic or transphobic remarks from providers. Transgender male participants described providers misgendering them (using incorrect

245pronouns), and prying into aspects of their identity irrelevant to the care being sought. A few
246transgender and genderqueer participants found that identity disclosure related to their
247reproductive medical care opened them up for transphobic mistreatment:

248 She asked to do the chest exam. And I was like, "I'm having top surgery in, less than a month. They're going to be
249gone." And she then gave me a lecture about how [my top surgery] is a poor life choice, and I need to reconsider
250things. "And, I don't even know what that would mean for your future." …in the end I didn't actually get anything
251out of [the exam], besides, "You're healthy, I guess," and "Take more ibuprofen." -25-year-old, biracial, queer,
252genderqueer person

253Here the provider scrutinized the patient's decision to pursue gender-affirming surgeries instead
254of providing relevant care, prompted by a discussion about a routine exam in reproductive
255healthcare settings. The patient left the appointment feeling that they had endured emotional
256discomfort disproportionate to care received.

257 Transgender men and genderqueer participants also described being met with
258discrimination when seeking medical advice related to gender transition. Both HRT and gender-
259affirming surgeries pertain to health of the reproductive system, so the choice to engage
260reproductive healthcare provider type felt logical. However, most described providers as ignorant
261of transgender-related health issues and some refused support of gender-affirming care. One
262participant described discussing HRT with their provider:

263I wanted to start hormones. And she was like, I don't know about all of that. And I was just like, but could you refer
264me to someone who does? And she was like, well, there's nothing wrong with being a woman, and just really
265believed that it was from a place of hate for women, just internalized hate for women that was making me ask her
266this. And that was my first time like coming out to a medical professional. -28-year-old, Hispanic, queer,
267genderqueer person

268After the patient's disclosure, the provider was described as conflating gender affirmation with 269misogyny. She then obstructed access to requested medical care by not providing a referral to an 270appropriate provider or engaging with the patient about their medical needs.

271 Interrogation about and invalidation of identity also occurred around sexual orientation. 272One participant described their first routine preventive care visit with a gynecologist. They 273disclosed their queer identity to the provider, who then:

274…spent the whole visit talking about his daughter's friend, who wasn't - who said that she wasn't straight, but she 275had sex with a guy who was cis[gender]…all while all the things that go along with being at the gynecologist are 276happening for the first time ever... Everything is too big and too hard and too fast and really terrible. And basically, 277his story was, "She ended up having a kid, and I delivered it. Because nobody is actually gay. And you always go 278back to men and have children, and she's straight." – 25-year-old, biracial, queer, genderqueer person

279The combination of gruff examination technique and homophobic comments made this 280participant feel distressed and disrespected. This juxtaposition within this participant's story 281highlights the heightened vulnerability reproductive healthcare settings generated for some 282participants.

283 The experience of providers saying discriminatory remarks instead of providing medical 284care made participants feel both uncomfortably visible and unwelcome in reproductive 285healthcare spaces.

286*Impact on reproductive healthcare-seeking behavior*

287 Participants also shared how previous reproductive healthcare experiences affected their 288desire to seek future care. Some who had negative prior experiences with reproductive healthcare 289have since avoided those care settings:

290 Being a rape survivor, being a non-binary person, and then my really only other experience in that kind of setting
291being negative or giving me a negative recollection of that, all of those things combined made me not want to go for
292the longest time. -29-year-old, White, queer, genderqueer person

293Many also discussed story-sharing about reproductive healthcare among LGBTQ FAAB persons.
294Statements from cisgender women like, "virtually every queer female I know has had the
295experience of having providers not take them at their word that they're not pregnant." (33-year-
296old, Hispanic, queer, genderqueer person) or, from genderqueer or transmasculine participants,
297"My friends, we have…the longest thread of horror stories getting Pap [smears]" [due to lack of
298provider sensitivity to patient discomfort with female reproductive organs] (28-year-old,
299Hispanic, queer, genderqueer person) were common among participants. A lesbian participant
300called reproductive healthcare "a running joke in the LGBTQ community" because of how
301incongruous so many feel in this setting. Negative experiences in reproductive healthcare
302settings, such as harassment or inappropriate treatment, not only impact individual healthcare
303seeking behavior, but also circulate though LGBTQ social networks.

304

305DISCUSSION

306 Our analysis of a cross-cutting sample of LGBTQ FAAB individuals highlights that LGBTQ
307FAAB individuals seeking reproductive healthcare have diverse needs and face unique
308challenges. To our knowledge, this is the first attempt to document the breadth of reasons that
309LGBTQ FAAB individuals --including lesbian, bisexual and queer women, genderqueer
310individuals, and transgender men -- pursue reproductive healthcare. Some participants, including
311lesbian and queer cisgender women and transgender men, want to have children and may need
312specialized care or information, such as assistance in insemination and—specifically for

313transgender men and genderqueer people—guidance on the impact of testosterone treatment on
314pregnancy. Some also seek reproductive healthcare for non-fertility-related health concerns,
315including symptom management for menstruation and PCOS and post-hysterectomy care.
316Transgender men and genderqueer individuals also engage reproductive health providers about
317gender-affirming care. While this is an exploratory as opposed to exhaustive list, it highlights the
318range of priorities for sexual and gender minorities across the reproductive lifespan. Research
319topics that participants wished to see pursued by researchers largely mapped onto the personal
320priorities conveyed, including experiences of LGBTQ groups through pregnancy, quality of
321reproductive healthcare, sexual behavior, and biomedical concerns. Reproductive health
322researchers should consider this diverse set of priorities when developing future studies.

323 Findings presented here on reproductive healthcare experiences are consistent with
324literature on quality of LGBTQ healthcare experiences. Previous research shows that two main
325barriers to quality healthcare access for LGBTQ adults are: lack of providers knowledgeable
326about LGBTQ health and fear of discrimination in healthcare settings (Bonvicini & Perlin, 2003;
327James, SE et al., 2016; Poteat, German, & Kerrigan, 2013; Roberts & Fantz, 2014). Reproductive
328healthcare—traditionally associated with womanhood and childbearing (Kimport, 2017)—is
329particularly disposed toward these offenses. This can create two related challenges. One, it can
330alienate individuals who need reproductive health services, but do not identify as female, or
331individuals not interested in childbearing and not at risk of pregnancy. And two, it can create
332inaccurate expectations for providers about who is seeking care and why. In our study, providers
333were described as largely unprepared or unresponsive to family formation methods or sexual
334behaviors that fall outside of cis- or heteronormative expectations.

335 Additionally, reproductive healthcare, where sexual activity and reproductive anatomy
336are central topics, lends itself toward disclosure of gender identity and sexual orientation. For
337multiple participants, including cisgender queer women and genderqueer individuals, the first
338time they disclosed sexual orientation or gender identity in a medical context was in a
339reproductive healthcare setting, due, in part, to the nature of care. Sexual orientation disclosure in
340clinical settings can lead to higher patient satisfaction (Bergeron & Senn, 2003; Steele,
341Tinmouth, & Lu, 2006), but disclosure also may be met with discriminatory treatment by
342providers.

343 Examples of provider discrimination and inexperience were described by participants in
344all gender identity and sexual orientation groups. For lesbian, bisexual and queer women and
345genderqueer individuals, assumptions about sexual activity and pregnancy, and childbearing
346desire created barriers to obtaining useful sexual and reproductive health guidance. Similar
347experiences have been documented in lesbian and bisexual women seeking pap testing (Agénor,
348Bailey, Krieger, Austin, & Gottlieb, 2015; Curmi, Peters, & Salamonson, 2016). For sexual
349minority women who seek prenatal care, pervasive heteronormativity can impede patient
350provider communication (Cherguit, Burns, Pettle, & Tasker, 2013; McManus, Hunter, & Renn,
3512006; Röndahl, Bruhner, & Lindhe, 2009).

352 For transgender men and genderqueer individuals FAAB, framing of reproductive healthcare
353as women's care can be an obstacle to presenting for care. Within care settings, attempts to
354disclose identity or seek guidance on gender-affirming care were, at times, erroneously reframed
355by providers as internalized misogyny, making patients feel unwelcome. Providers were also
356described as unable to provide useful information or referrals for transgender patients. This is
357consistent with literature that shows that providers are unprepared to provide guidance on pap

tests for transgender men (Agénor et al., 2015) or provide transgender men adequate support and resources throughout prenatal care (Light et al., 2014). If transgender men seek referrals to transition-related care through unprepared providers, their entry into care may be delayed, which can impact quality of life (White Hughto & Reisner, 2016).

Discrimination in reproductive healthcare settings and low-quality care provision may impact health outcomes for these groups across the reproductive lifespan. Transgender men who have sex with cisgender men may be at increased risk of HIV acquisition (Reisner & Murchison, 2016). Young bisexual women report higher rates of risky sexual behavior (Marrazzo & Gorgos, 2012). Avoidance of sexual healthcare or inadequate examination within healthcare settings may lead to missed screening or treatment. Similarly, lack of pap testing is equated with higher rates of cervical cancer mortality (Landy, Pesola, Castañón, & Sasieni, 2016). Future research should document health outcomes related to inadequate reproductive healthcare by these groups.

Limitations

As our study was exploratory, there are limitations. Data were drawn from a convenience sample, and findings may not be generalizable to all LGBTQ FAAB individuals. We utilized various recruitment channels to diversify our sample, however, our final sample was predominantly White, urban, and educated. Participants may have different reproductive healthcare priorities and experiences and better access to care than those not represented in our study. We were unable to reach individuals with less access to physical and/or virtual social networking sites, which likely included less-educated, lower-income, and housing-unstable individuals. These individuals may face additional barriers to quality healthcare due to lack of coverage or under-insured status that limits their healthcare options. To better recruit hard-to-reach individuals, future studies could consider intensive community engagement and utilization

381of peer recruitment (Tourangeau, Edwards, Johnson, Wolter, & Bates, 2014). Many participants
382chose to participate in order to share their experiences, which may have influenced
383overrepresentation of negative experiences within our study. Future research should investigate
384what facilitates reproductive healthcare access for LGBTQ FAAB indiivduals. Similarly, we did
385not purposefully seek out representation from individuals with no previous exposure to
386reproductive healthcare and cannot comment on how their priorities may deviate. Our decision to
387include participants across a range of sexual orientations and gender identities allowed us to
388comment on cross-cutting themes, however, we could not analyze experiences unique to each
389included group. Future research should explore these topics in each group separately.

390**Implications for Practice and/or Policy**

391 Reproductive health priorities of LGBTQ FAAB individuals include needs similar to
392cisgender and heterosexual groups (e.g. abortion, contraception, PCOS management), as well as
393unique needs (e.g. gender-affirming hysterectomies, inclusive safer sex guidance) and challenges
394to accessing relevant care. Discriminatory treatment in reproductive healthcare settings can
395impede access to important medical care, such as cervical cancer screening (Agénor et al., 2015;
396Curmi et al., 2016; Johnson, Mueller, Eliason, Stuart, & Nemeth, 2016) and prenatal care (Light
397et al., 2014). Our study identified mechanisms through which discrimination and exclusion
398manifest in reproductive healthcare broadly, including imprecise protocols, marginalization and
399denial of patient priorities, and irrelevant focus on fertility. These qualities, alongside overt
400discrimination, can influence reproductive healthcare avoidance among LGBTQ FAAB
401individuals. Future reproductive health research should pursue healthcare concerns prioritized by
402LGBTQ FAAB individuals.

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406Acknowledgements: We would like to thank our study participants for their time. This study was
407supported by an internal ANSIRH grant funded by a gift fund. We would also like to thank Rana
408Barar, Rebecca Kriz, Brenly Rowland, Finley Baba, Jasmine Powell, and Diana Greene-Foster
409for administrative support and guidance on this project.

410

411

412**References**

413Agénor, M., Bailey, Z., Krieger, N., Austin, S. B., & Gottlieb, B. R. (2015). Exploring the
414 Cervical Cancer Screening Experiences of Black Lesbian, Bisexual, and Queer Women:
415 The Role of Patient-Provider Communication. *Women & Health*, *55*(6), 717–736.
416 https://doi.org/10.1080/03630242.2015.1039182

417Agénor, M., Krieger, N., Austin, S. B., Haneuse, S., & Gottlieb, B. R. (2014). Sexual orientation
418 disparities in Papanicolaou test use among US women: the role of sexual and
419 reproductive health services. *American Journal of Public Health*, *104*(2), e68-73.
420 https://doi.org/10.2105/AJPH.2013.301548

421Agénor, M., Muzny, C. A., Schick, V., Austin, E. L., & Potter, J. (2017). Sexual orientation and
422 sexual health services utilization among women in the United States. *Preventive*
423 *Medicine*, *95*, 74–81. https://doi.org/10.1016/j.ypmed.2016.11.023

424Agrawal, R., Sharma, S., Bekir, J., Conway, G., Bailey, J., Balen, A. H., & Prelevic, G. (2004).
425 Prevalence of polycystic ovaries and polycystic ovary syndrome in lesbian women

426 compared with heterosexual women. *Fertility and Sterility*, *82*(5), 1352–1357.
427 https://doi.org/10.1016/j.fertnstert.2004.04.041
428Bergeron, S., & Senn, C. Y. (2003). Health care utilization in a sample of Canadian lesbian
429 women: predictors of risk and resilience. *Women & Health*, *37*(3), 19–35.
430 https://doi.org/10.1300/J013v37n03_02
431Bonvicini, K. A., & Perlin, M. J. (2003). The same but different: clinician-patient communication
432 with gay and lesbian patients. *Patient Education and Counseling*, *51*(2), 115–122.
433Cherguit, J., Burns, J., Pettle, S., & Tasker, F. (2013). Lesbian co-mothers' experiences of
434 maternity healthcare services. *Journal of Advanced Nursing*, *69*(6), 1269–1278.
435 https://doi.org/10.1111/j.1365-2648.2012.06115.x
436Cipres, D., Seidman, D., Cloniger, C., Nova, C., O'Shea, A., & Obedin-Maliver, J. (2017).
437 Contraceptive use and pregnancy intentions among transgender men presenting to a clinic
438 for sex workers and their families in San Francisco. *Contraception*, *95*(2), 186–189.
439 https://doi.org/10.1016/j.contraception.2016.09.005
440Curmi, C., Peters, K., & Salamonson, Y. (2016). Barriers to cervical cancer screening
441 experienced by lesbian women: a qualitative study. *Journal of Clinical Nursing*, *25*(23–
442 24), 3643–3651. https://doi.org/10.1111/jocn.12947
443De Sutter, P., Dutré, T., Vanden Meerschaut, F., Stuyver, I., Van Maele, G., & Dhont, M. (2008).
444 PCOS in lesbian and heterosexual women treated with artificial donor insemination.
445 *Reproductive Biomedicine Online*, *17*(3), 398–402.
446Ellis, S. A., Wojnar, D. M., & Pettinato, M. (2015). Conception, pregnancy, and birth experiences
447 of male and gender variant gestational parents: it's how we could have a family. *Journal*
448 *of Midwifery & Women's Health*, *60*(1), 62–69. https://doi.org/10.1111/jmwh.12213

449Fusch, P. I., & Ness, L. R. (2015). Are We There Yet? Data Saturation in Qualitative Research.
450 *The Qualitative Report*, *20*(9), 1408–1416.
451Gender Identity in U.S. Surveillance (GenIUSS). (2014). *Best Practices for asking questions to*
452 *identify transgender and other gender minority respondents on population-based surveys*.
453 Los Angeles, CA: The Williams Institute on Sexual Orientation, Law & Public Policy,
454 UCLA School of Law.
455Ingraham, N., Wingo, E., Foster, D., & Roberts, S. (2017). Best practices for LGBTQ inclusion
456 and exclusion in reproductive health research. *Contraception*, *96*(4), 299.
457 https://doi.org/10.1016/j.contraception.2017.07.138
458Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues
459 and Research Gaps and Opportunities. (2011). *The Health of Lesbian, Gay, Bisexual, and*
460 *Transgender People: Building a Foundation for Better Understanding*. Washington, DC:
461 National Academies Press.
462Society of Family Planning Interdisciplinary Innovation (I2) Phase 1 grant recipient,
463 "Reproductive health access among transgender and gender expansive individuals."
464 (n.d.). Society of Family Planning website. Retrieved from
465 https://www.societyfp.org/Research-and-grants/Grants-funded/Sarah-Baum-2017.aspx
466James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report*
467 *of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender
468 Equality.
469Johnson, M. J., Mueller, M., Eliason, M. J., Stuart, G., & Nemeth, L. S. (2016). Quantitative and
470 mixed analyses to identify factors that affect cervical cancer screening uptake among

471 lesbian and bisexual women and transgender men. *Journal of Clinical Nursing*, *25*(23–
472 24), 3628–3642. https://doi.org/10.1111/jocn.13414
473Kimport, K. (2017). More Than a Physical Burden: Women's Mental and Emotional Work in
474 Preventing Pregnancy. *The Journal of Sex Research*, 1–10.
475 https://doi.org/10.1080/00224499.2017.1311834
476Knight, D. A., & Jarrett, D. (2017). Preventive Health Care for Women Who Have Sex with
477 Women. *American Family Physician*, *95*(5), 314–321.
478Landy, R., Pesola, F., Castañón, A., & Sasieni, P. (2016). Impact of cervical screening on cervical
479 cancer mortality: estimation using stage-specific results from a nested case–control study.
480 *British Journal of Cancer*, *115*(9), 1140–1146. https://doi.org/10.1038/bjc.2016.290
481Light, A. D., Obedin-Maliver, J., Sevelius, J. M., & Kerns, J. L. (2014). Transgender Men Who
482 Experienced Pregnancy After Female-to-Male Gender Transitioning: *Obstetrics &*
483 *Gynecology*, *124*(6), 1120–1127. https://doi.org/10.1097/AOG.0000000000000540
484MacDonald, T., Noel-Weiss, J., West, D., Walks, M., Biener, M., Kibbe, A., & Myler, E. (2016).
485 Transmasculine individuals' experiences with lactation, chestfeeding, and gender identity:
486 a qualitative study. *BMC Pregnancy and Childbirth*, *16*, 106.
487 https://doi.org/10.1186/s12884-016-0907-y
488Marrazzo, J. M., & Gorgos, L. M. (2012). Emerging Sexual Health Issues Among Women Who
489 Have Sex with Women. *Current Infectious Disease Reports*.
490 https://doi.org/10.1007/s11908-012-0244-x
491McManus, A. J., Hunter, L. P., & Renn, H. (2006). Lesbian Experiences and Needs During
492 Childbirth: Guidance for Health Care Providers. *Journal of Obstetric, Gynecologic &*
493 *Neonatal Nursing*, *35*(1), 13–23. https://doi.org/10.1111/j.1552-6909.2006.00008.x

494Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods (3rd Ed.)*. Thousand Oaks,
495 CA: SAGE Publications.
496Peitzmeier, S. M., Khullar, K., Reisner, S. L., & Potter, J. (2014). Pap test use is lower among
497 female-to-male patients than non-transgender women. *American Journal of Preventive*
498 *Medicine*, *47*(6), 808–812. https://doi.org/10.1016/j.amepre.2014.07.031
499Pérez-Stable, E. J. (2016, October 6). Sexual and Gender Minorities Formally Designated as a
500 Health Disparity Population for Research Purposes. Retrieved from
501 https://www.nimhd.nih.gov/about/directors-corner/message.html
502Pope, C. (2000). Qualitative research in health care: Analysing qualitative data. *BMJ*, *320*(7227),
503 114–116. https://doi.org/10.1136/bmj.320.7227.114
504Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: A grounded theory of
505 stigma in transgender health care encounters. *Social Science & Medicine*, *84*, 22–29.
506 https://doi.org/10.1016/j.socscimed.2013.02.019
507Reisner, S. L., & Murchison, G. R. (2016). A global research synthesis of HIV and STI
508 biobehavioural risks in female-to-male transgender adults. *Global Public Health*, *11*(7–
509 8), 866–887. https://doi.org/10.1080/17441692.2015.1134613
510Ritchie, J., & Lewis, J. (Eds.). (2014). *Qualitative research practice: a guide for social science*
511 *students and researchers* (2nd. ed). London: SAGE.
512Roberts, T. K., & Fantz, C. R. (2014). Barriers to quality health care for the transgender
513 population. *Clinical Biochemistry*, *47*(10–11), 983–987.
514 https://doi.org/10.1016/j.clinbiochem.2014.02.009

515Robinson, O. C. (2014). Sampling in Interview-Based Qualitative Research: A Theoretical and
516 Practical Guide. *Qualitative Research in Psychology*, *11*(1), 25–41.
517 https://doi.org/10.1080/14780887.2013.801543
518Röndahl, G., Bruhner, E., & Lindhe, J. (2009). Heteronormative communication with lesbian
519 families in antenatal care, childbirth and postnatal care. *Journal of Advanced Nursing*,
520 *65*(11), 2337–2344. https://doi.org/10.1111/j.1365-2648.2009.05092.x
521Schwartz, S. R., & Baral, S. (2015). Fertility-related research needs among women at the
522 margins. *Reproductive Health Matters*, *23*(45), 30–46.
523 https://doi.org/10.1016/j.rhm.2015.06.006
524Smith, H. A., Markovic, N., Matthews, A. K., Danielson, M. E., Kalro, B. N., Youk, A. O., &
525 Talbott, E. O. (2011). A comparison of polycystic ovary syndrome and related factors
526 between lesbian and heterosexual women. *Women's Health Issues: Official Publication of*
527 *the Jacobs Institute of Women's Health*, *21*(3), 191–198.
528 https://doi.org/10.1016/j.whi.2010.11.001
529Somers, S., Van Parys, H., Provoost, V., Buysse, A., Pennings, G., & De Sutter, P. (2017). How to
530 create a family? Decision making in lesbian couples using donor sperm. *Sexual &*
531 *Reproductive Healthcare: Official Journal of the Swedish Association of Midwives*, *11*,
532 13–18. https://doi.org/10.1016/j.srhc.2016.08.005
533Steele, L. S., Tinmouth, J. M., & Lu, A. (2006). Regular health care use by lesbians: a path
534 analysis of predictive factors. *Family Practice*, *23*(6), 631–636.
535 https://doi.org/10.1093/fampra/cml030
536Tornello, S. L., & Bos, H. (2017). Parenting Intentions Among Transgender Individuals. *LGBT*
537 *Health*. https://doi.org/10.1089/lgbt.2016.0153

538Tourangeau, R., Edwards, B., Johnson, T., Wolter, K., & Bates, N. (Eds.). (2014). *Hard-to-survey*
539 *populations*. New York: Cambridge University Press.
540White Hughto, J. M., & Reisner, S. L. (2016). A Systematic Review of the Effects of Hormone
541 Therapy on Psychological Functioning and Quality of Life in Transgender Individuals.
542 *Transgender Health*, *1*(1), 21–31. https://doi.org/10.1089/trgh.2015.0008
543